

Background Information

Primary Language: _____

Any other languages spoken? Please list: _____

Education Completed and Major: _____
Name of Current Employer: _____
Current/Previous Occupation: _____

Current Household Members and Relationship to You:

1. Please describe the communication problem you are having.

2. When and how did the difficulty begin? Did the problem begin suddenly or gradually?

3. How would you rate the severity of the problem now?
 Mild Moderate Moderately Severe Severe

4. Describe what you think may have caused this problem, and/or any situation or condition that you associate with this problem.

5. Describe any changes or variations that you have noticed in the problem since it began.

Background Continued

6. Have you had a speech and language evaluation/treatment at any other hospital or clinic? Y | N (if yes, please fill in the below.)
Name of Clinic: _____
Address: _____
Date of Evaluation: _____
Type of Treatment: _____

7. Have you seen any other specialist regarding your problem?

Specialist Name: _____

When: _____

Facility Name: _____

8. Describe anything you have done to improve your problem.

Speech , Language, Hearing and Cognitive Questionnaire

1. Please check any of the following characteristics that are true for you now:

- _____ have difficulty recalling names of people, objects etc.
- _____ have difficulty speaking in complete well-organized sentences
- _____ have difficulty swallowing foods or liquids
- _____ mispronounce or omit a sound or sounds while speaking
- _____ have a problem pronounced foreign or regional accent
- _____ have difficulty coordinating voice, tongue, lips etc to produce speech
- _____ Experience drooling while talking
- _____ feel overly tense while talking
- _____ stutter (or stammer) while talking
- _____ repeat sounds, words, parts of words or phases in regular talk
- _____ have difficulty, or pause, before saying certain words or sounds
- _____ hold breath while talking
- _____ seem to be out of breath while talking
- _____ notice voice hoarse most of time
- _____ have a pain in throat while speaking
- _____ notice voice sounds like it is coming through the nose
- _____ notice voice always sounds like I have a cold
- _____ notice that people complain that I always talk to softly or too loud
- _____ notice voice is abnormally low-pitched or high pitched
- _____ notice voice is worse at certain times of the day or certain seasons
- _____ feel my speech is normal
- _____ have problems remembering events or appointments
- _____ have problems solving daily problems
- _____ have problems organizing complex events (e.g. trip planning)
- _____ have problems with reading and/or writing (briefly describe)
- _____ have problems understanding other people (briefly describe)

2. Please check any of the following characteristics that are true of your hearing now.

- _____ have no difficulty hearing
- _____ have hearing loss in my Right Left Both ears
- _____ can hear but cannot understand when people talk to me
- _____ prefer having the television turned louder than those around me
- _____ have difficulty hearing in a one-to-one situation
- _____ have difficulty hearing in groups
- _____ have difficulty hearing on the phone

3. When was your last hearing test

When: _____

Where: _____

4. Do you wear hearing aid(s) or an implanted hearing device?
 Yes No
 If yes, please provide a brief description of your hearing aid and/or cochlear implant use:

5. Are there any difficulties with your device that you would like us to know about?

6. Have you been exposed to loud sounds (gunfire, loud music, heavy machinery, power tools, etc.)? Yes | No
 Where: _____

Medical History

1. List all present disabilities or health problems:

2. Are you currently under medical treatment or medication? (List or Describe)

Medical History Continued

3. List and describe any hospitalization, operations or accidents? Please indicate dates:

4. Please indicate if you have had any of the following:

<input type="checkbox"/> adenoidectomy	<input type="checkbox"/> lead poisoning
<input type="checkbox"/> allergies	<input type="checkbox"/> measles
<input type="checkbox"/> asthma	<input type="checkbox"/> meningitis
<input type="checkbox"/> chicken pox	<input type="checkbox"/> mumps
<input type="checkbox"/> colds (frequent)	<input type="checkbox"/> pneumonia

_____ croup or excessive coughing	_____ ringing in ears
_____ diabetes	_____ seizures
_____ dizziness	_____ or convulsions
_____ ear ache or ear infections	_____ sinus trouble or post nasal drip
_____ fainting spells	_____ sore throat (frequent)
_____ fever (high)	_____ thyroid disease
_____ headaches	_____ tuberculosis
_____ heartburn	_____ other: _____
_____ laryngitis (frequent)	_____

Family Medical History

Please indicate if you or any relatives on either side of the family have had the following:

	Self	Mother's Side	Father's Side
Behavior problems, including hyperactivity			
Drug or Alcohol abuse			
History of smoking			
Emotional or psychiatric problems			
Learning problems			
Ambidexterity or left hand preference			
Intellectual Disability			
Other Neurological problems			

Developmental and Educational History

- Describe any developmental problems during infancy or early childhood (i.e. late in walking, feeding problems, allergies, late in talking etc.)

- Describe any learning or reading problems you experienced as a child or are currently experiencing:

- Have any other members of your family had speech and/or hearing difficulties? Please describe

Personal History

- What are your hobbies/leisure activities?

2. Is there anything else you think may be important or would like to indicate or think may be important?

If, in order to help you, it would be appropriate to send or receive reports from other education / health care professionals, please indicate your permission by signing the provided consent form.

For Clinician Only

Additional notes
